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Notions of policy effectiveness and implications for policy design: insights from public-private partnerships in India

Altaf Virani

Lee Kuan Yew School of Public Policy, National University of Singapore, Singapore

ABSTRACT

The objective of policy design is to devise policies for the achievement of predetermined policy goals. Their effectiveness hinges on a determination of what constitutes policy success, and assessments of the suitability of different design configurations in attaining the intended outcomes. Failure to clearly specify policy goals and ascertain policy success (or failure) can thus render them ineffective. Goal ambiguities are particularly problematic in the context of collaborative policy instruments like Public-Private Partnerships (P3s) due to the multiplicity of stakeholder interests. Using the example of P3s in India's healthcare sector, this paper points to inherent contradictions in the policy expectations of different actors, and how policies which neglect an appreciation of the agendas of diverse constituencies are inherently unworkable and produce outcomes which are inequitable and inconsistent with their underlying motivations. By situating these cases against the academic discussion on frame-multiplicity and policy success, the paper highlights why policymakers must consider these different, sometimes conflicting ideas of effectiveness, and how they can be reconciled through proactive design efforts, so that policies are sustainable and effective in meeting their overarching goals.

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1. Goal ambiguity as an impediment to effective design

There is consensus among contemporary policy scholars that the main goal of policy design is effectiveness (Bali, Capano, and Ramesh 2019; Peters et al. 2018). All policymaking in theory is geared towards a single purpose – to achieve governmental objectives, whatever they may be. Sometimes these are concerned with improving the efficiency of public systems. At other times, they are to enhance transparency in public works, improve access to governmental services, or simply win elections through populist programs. While there is often more than one objective, and objectives can evolve with time, the goal of policy design remains the same i.e. to design policies

CONTACT Altaf Virani altaf.virani@yahoo.com Lee Kuan Yew School of Public Policy, National University of Singapore, 469C Bukit Timah Road, Singapore 259772

that can effectively help governments achieve their objectives. This philosophy is reflected in Harold Laswell's problem-centered approach to policymaking (Lasswell 1951), the design-oriented principles of public management (Barzelay and Thompson 2007) and recent work on policy instruments and mixes (Howlett 2019; Peters 2018b). Effectiveness is therefore a key criterion that must guide instrument choice, and a credible test against which policy performance must be evaluated. A good policy design is one that works (Peters 2018a).

However, policies have multiple effects, not all of them desirable, which presents challenges for policymakers. Such dilemmas are observed in the adoption of Public-Private Partnerships (P3s) by governments for strengthening public infrastructure and services. On the one hand, P3s have been welcomed by its proponents as an answer to the inadequacy, inefficiency and incompetence of traditional public service provision (Borins 1995). In the health sector, for example, they have been known to improve the performance and quality of healthcare and allied services (Bisht and Virani 2016; Liu, Hotchkiss, and Bose 2008; Lönnroth, Uplekar, and Blanc 2006). On the other hand, critics have questioned their lack of democratic accountability, negative effects on equity and access, and diminutive effects on the role of the state (Baru and Nundy 2008; Bisht and Virani 2016). Because policies are complex in their manifestations, policymakers have to tread a fine balance in determining optimal design configurations. Recent literature on policy mechanisms suggests that for policies to be effective, policymakers must consider the different mechanisms that policy instruments might activate, and create designs that can leverage them to maximize social gains and attenuate unintended effects (Capano, Howlett, and Ramesh 2019). Failure to recognize the different behavioral responses triggered by activating instruments and reverse engineer suitable designs to elicit required behavioral change can result in policy failure (Virani and Ramesh 2019; Weaver 2019). However, a more basic failure arises from ambiguity on the end goals of policy, which makes it impossible to work backwards to evolve suitable designs (Howlett 2019). In the context of public programs, goal ambiguity can be defined as "the extent to which a set of goals in a public program allows different interpretations in deciding work related to target, time limit, and external evaluation" (Jung 2012). Such ambiguities create a faultline in the design process and lead to ineffectual results (Figure 1). While policies can fail at multiple levels, this failure is more fundamental, difficult to overcome and likely to result in policy chaos, as it renders subsequent steps in the design chain inconsequential, and successive design iterations ineffective.[1]

Given the iterative nature of the design process and laws of natural selection, one might expect ineffective policies to be quickly terminated. However, effective policies do not always survive, while ineffective ones can persist (Geva-May 2004; Hodge and Greve 2011). Such vagaries are widely prevalent among P3s. Their extensive use in restructured economies has not always been supported by evidence on their effectiveness (Datta 2009; Karpagam et al. 2013; Planning Commission 2012). P3s in India's health sector are a case in point. Many of the existing projects are mired in controversy and face allegations of perverse provider behavior, breach of contract and inequitable access (Bisht and Virani 2016; Donaldson, Sethi, and Sharma 2008; SAMA 2012). Ironically though, P3s continue to be the preferred strategy for public health

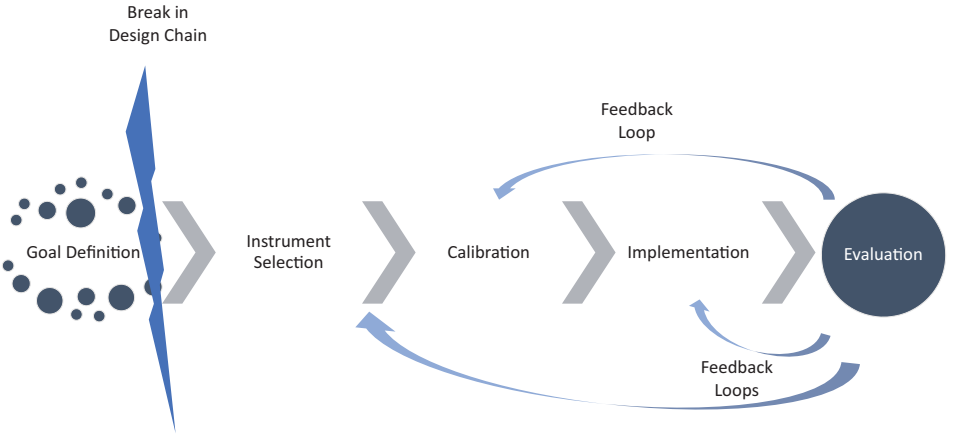

Figure 1. Goal-design mismatch.

infrastructure creation in under-served areas, despite majority evidence of ineffectiveness (Datta 2009; Karpagam et al. 2013; Planning Commission 2012). At the same time, seemingly useful projects have been terminated despite pleas from local communities and elected representatives for continuance (Anon 2012). Some explanations for this paradox emerge from termination literature. Policies are influenced by several contextual considerations and pressures, and policies that get implemented or remain in vogue are not simply a function of their effectiveness. Policymakers often find termination a politically unpragmatic option, so policies tend to persist even when they are widely viewed as having failed in achieving their goals (Weaver 2010). Governmental peculiarities, their predilection for stability and the political, emotional, financial and legal costs associated with policy change further inhibit termination-related decisions (Geva-May 2004). Experiences with water privatization show that barring grossly inefficient provision, factors such as inter-governmental conflict, bureaucratic inertia, corruption and political volatility often prevent cancelations that may otherwise have been desirable from a public interest perspective (House 2014; Kivleniece 2013). On the other hand, opportunistic manipulation by actors in favor of termination, abrupt changes in administrative regimes, delegitimization of political ideologies, political turbulence and in-built policy features that facilitate dissolution, might create conditions for termination of policies even when they appear to be effective (Bardach 1976; Geva-May 2004; Kingdon and Thurber 1984).

While the effects of these political influences on policy are obvious, the role of goal multiplicity and framing in determining policy outcomes is often overlooked. Interactions between policy actors both within and outside the government involve exchanges between different conceptions of rationality, borne out of their relative positions within the policy space (Bovens and Hart 1995). Governments typically have multiple policy goals based on jurisdictional and sectoral policy preferences which may or may not be consistent with one another, or with those of other non-public participants. Achieving some may require sacrificing others. O'Toole (1989) discusses the case of wastewater treatment to explain how privatization might improve performance in cleaning cities' water, but might also lead to reduced

autonomy for city councils. Because policy goals are multidimensional, lack of general agreement on what constitutes policy success can be a major source of ineffectiveness. Very rarely do policy actors converge in their opinions about policy outcomes or how policy problems are defined (Daniels 1997; Lewis 2002; Peters 2018b). Because performance is a relative construct, stakeholders may vary significantly in their assessments depending on what standards they are holding them to. Some assessments may be weightier than others, so favorable appraisals by the more influential actors and their perceptions of performance play a critical role in determining policy survival. This phenomenon is particularly germane in the context of P3s where at least three distinct stakeholders with clearly different worldviews and motivations are involved – the government, the private sector partner and the community of end users. Hodge and Greve (2011) contend that governments frequently interpret P3 outcomes in ways that suit political interests. Other than extensive corruption or gross incompetence, P3 projects are by and large judged to be successful by governments seeking to encourage them. Policymakers thus use the multiplicity of plausible performance goals to put a positive spin on achieved outcomes. Moreover, the goals of public agencies are more amorphous than their private sector partners (Reynaers and van der Wal 2018). Such ambiguities can have positive effects on P3 functionality by providing more operational space and flexibility than what conformity requirements with rigid expectations might allow for in complex collaborative projects. Adaptive mechanisms such as incomplete and relational contracts, for instance, leverage such non-specificities in pursuit of optimal outcomes (Darwin, Duberley, and Johnson 2000). However, they can also present design challenges as flawed designs can cause partners to work at cross-purposes and lead to accountability problems (Hodge and Greve 2010; Teisman and Klijn 2002a, 2002b). Such designs are inherently unworkable and tend to produce outcomes which are inequitable and inconsistent with their underlying motivations. It is, therefore, important to identify the broad parameters of policy success, and set outcome expectations for each partner prospectively at the design stage and through ongoing engagement, to reduce space for outright obfuscation, and to better direct design efforts to enhance effectiveness towards those outcomes.

2. Dimensions of P3 effectiveness and perspectives of success

Policy scholars have evolved normative frameworks for conceptualizing policy success in its varied manifestations. Perhaps the best-known work is that of Marsh and McConnell (2010) and McConnell (2010a, 2010b), which provides a conceptual foundation for interpreting policy fitness through diverging perceptions of policy success. It proposes dimensions of policy assessment in programmatic, process, and political terms. Programmatic assessments are focused on goal attainment, i.e. a policy's ability to achieve intended and/or other beneficial outcomes. Process assessments evaluate the means through which policy aspirations are translated into policy instruments, and the extent to which these processes enjoy stakeholder support. Political assessments seek to evaluate the degree of electoral support and political dividends garnered by a policy. Policies are thus deemed to be successful if they produce valued social outcomes and

enjoy stakeholder support and political legitimacy (Compton and 't Hart 2019a, 2019b). More recent work by Newman (2014) has suggested the additional inclusion of distributional outcomes as a distinct dimension, to gauge the manner in which a policy advances the cause of different social groups or disfavors them, and the extent to which they are affected. This last dimension is particularly relevant in the context of P3s which often present contested notions of effectiveness by different stakeholders. However, such assessments are quite challenging. Despite increasing trends of public service delivery through P3 procurement, there are surprisingly few evaluations of P3 projects, especially in the developing world, and little empirical data on their effectiveness (Bhat 2000; Datta 2009; Hodge and Greve 2007; Karpagam et al. 2013). Few studies have attempted to capture the diversity in formulations of success by different stakeholders. Most empirical evaluations in India for instance, have looked at P3 performance from singular perspectives and on exclusive, sometimes diverging parameters of success (Raman and Björkman 2008). There has been limited discussion in the academic literature on anecdotally observed differences in concurrent assessments of P3 projects by different stakeholders, and the effects of design arrangements on producing these disparities in end outcomes. The piecemeal approach makes it difficult to evaluate P3 success, as such determinations are inevitably clouded by partisan perspectives, resulting in the implementation of partnerships that do not truly represent their collaborative principles (Pillay, Watters, and Hoff 2013).

To overcome fragmented assessments and gaps in systematic evaluation, a practical heuristic is suggested in this paper for mapping P3 performance across groups of key performance indicators (KPIs) drawn from conventional P3 policy literature and case study material (Ahmed 2000; Raman and Björkman 2008). These indicators are grouped within four basic dimensions of effectiveness: (i) cost – the economic cost of procurement for the government, returns on investment (RoI) for the private partner and the price paid by consumers; (ii) performance – the achievement of efficiency, resource optimization, utilization, quality improvement, and scale; (iii) equity – acceptable quality of services for all, equitable cost-sharing, universal and fair distribution, and inclusion of marginalized groups; and (iv) accountability – holding service providers accountable to beneficiaries and other stakeholders on program processes and outcomes, transparent procurement, participatory decision-making, contract enforcement, regulatory compliance and answerability to the electorate (Figure 2). While neither definitive nor exhaustive, the heuristic provides a crude but functional method to organize and make sense of different types of information pertaining to P3 performance that can be used to analyze policy effectiveness from the perspectives of diverse stakeholders. Because stakeholders have different expectations, and P3s may perform differently on different parameters of effectiveness (even on the same dimension), stakeholders might come away with different assessments of effectiveness.

Performance assessed using this tool can be subsequently recast using the Marsh-McConnell-Newman framework to gauge P3 effectiveness across the four main categories of evaluation outcomes (programmatic, distributive, process, and political) (Figure 3). Such reorganization can help synthesize a holistic picture of effectiveness, and examine the nuances of how a P3 venture might have succeeded or failed, and how different stakeholders might have been affected by it. Also, because different

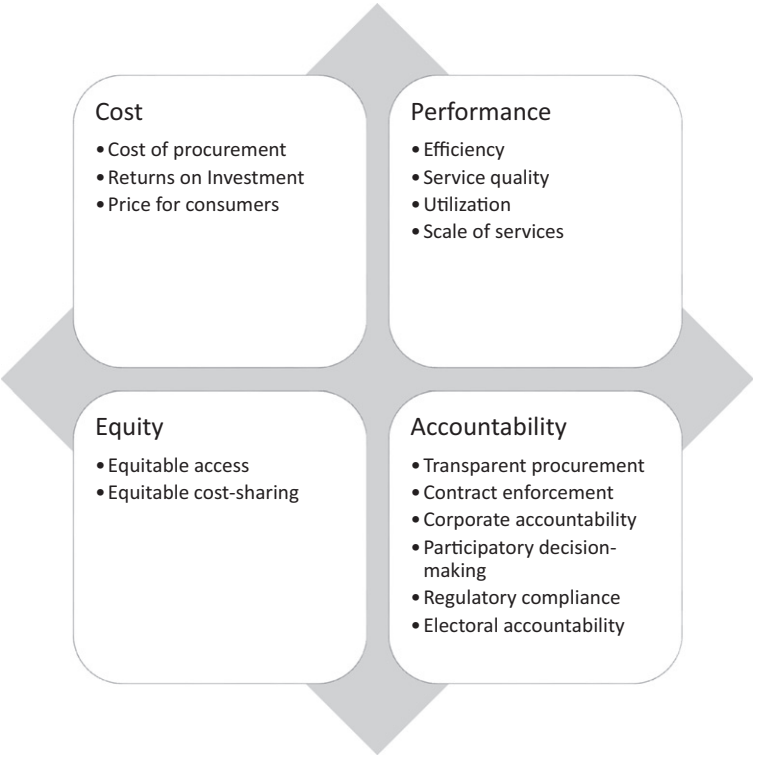

Figure 2. Dimensions of P3 effectiveness.

design elements in a P3 portfolio might serve different purposes, and seek to trigger different sets of outcomes, this approach can potentially help to draw linkages between different design configurations and outcomes.

3. P3 performance in India's health sector and the policy substructure

Budgetary and resource constraints have led governments in India at both the federal and state levels to actively promote P3s to supplement the crumbling public system, and create critically required public infrastructure and services. In the health sector. These efforts are reflected through policies and programs promoting P3s since the 1990s (Bali and Ramesh 2015; Bhat 2000; Maurya, Virani, and Rajasulochana 2017). These include a variety of arrangements, from the use of private contractors in supportive services, to their engagement in the provision of core medical services. National and state-level programs have employed contracted private healthcare providers for delivering maternal care services in rural areas. Pharmacies have been set up in every district through P3 arrangements to sell affordable, high-quality generic drugs and surgical products. State-financed social insurance programs have empaneled private hospitals to provide healthcare services to enrolled beneficiaries. More traditional P3 arrangements such as Concessions, Build-Operate-Transfer (BOT) and Design-Build-Operate (DBO) projects and joint ventures have engaged the private sector in the construction and management of public hospitals, in exchange for

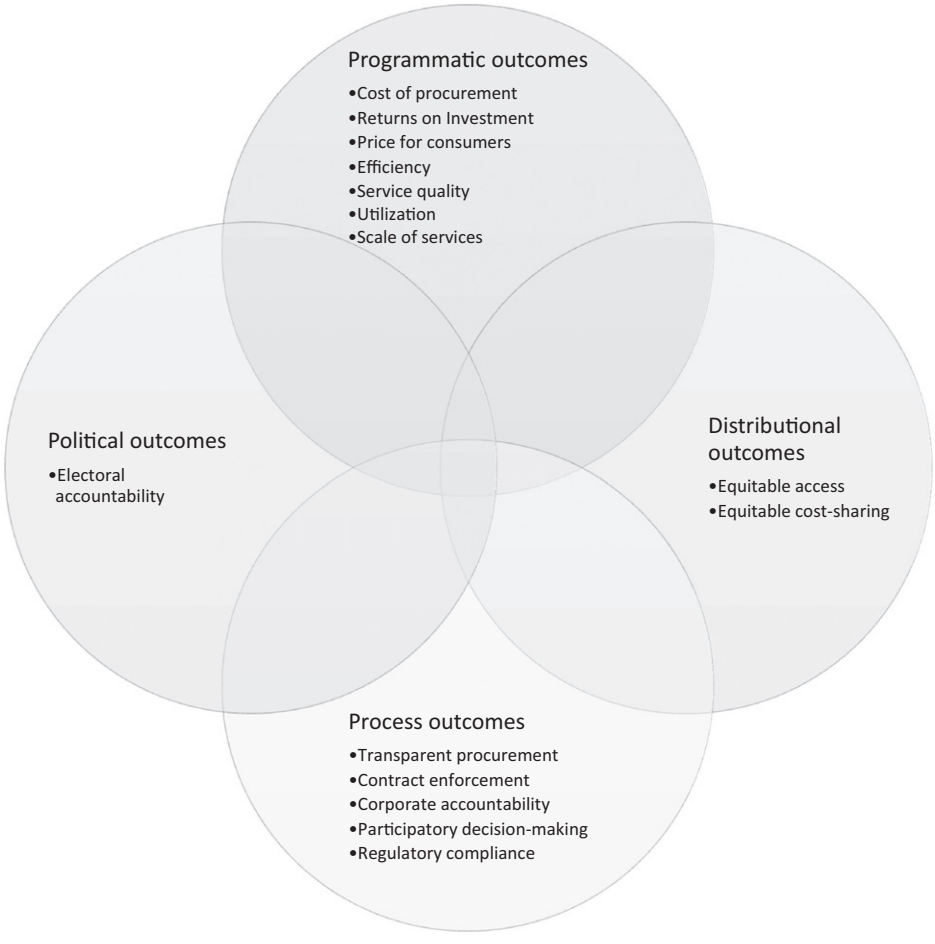

Figure 3. Categories of P3 outcomes based on the Marsh-McConnell-Newman framework.

financial incentives or fixed contractual emoluments (Planning Commission 2012). Such hospital-based projects are mostly fragmented initiatives implemented in an *ad-hoc* manner, delinked from long-term policy considerations. State and local governments commission them based on short-term priorities, service requirements, fiscal situations, and political pulls and pushes. While P3s have been officially recognized as a policy means for achieving India's public health goals (Ministry of Health and Family Welfare 2013) there is lack of clarity on what specific gaps they are expected to address (e.g. financing, human resource, and management deficiencies) and no prescription for how these gaps can be bridged. Most projects operate outside the purview of any formal policy or governing institution, except for oversight by the procuring line-agency or ministerial department (Hans 2017).

Case-study evidence from some of these projects has identified a set of common problems: (1) objectives of most projects are fuzzy and ambiguous; (2) deliverables are seldom well-defined; (3) implementation is opaque; (4) performance is rarely evaluated; and (5) institutional capacity to manage and monitor is limited (Bhat 2000; Raman and

Björkman 2008). Each of these affect performance in two ways. First, they limit P3 effectiveness. Second, they make it difficult to assess effectiveness, which makes continual design refinements challenging.

There have been recent attempts to provide policy direction for P3s, in the form of exclusive policies as in the case of housing development, or integrated within existing sector strategies as for infrastructure projects like Metro rail. In healthcare, however, no tailored policy exists. A generic national P3 policy drafted in 2011 for consultation is yet unenacted (Department of Economic Affairs 2011). It provides templates for organizing P3s for hospitals, diagnostic centers, and medical colleges, but lacks critical sector specific adjustments or linkages with health sector policies.[2] While it is noteworthy that the policy lays emphasis on removing bureaucratic red tape, provides a blueprint for project governance, stipulates clear procurement guidelines, and strengthens state-level capacity building efforts through P3 cells, the focus is clearly on cost-cutting, process optimization, process accountability, curbing *ad-hoc* procurement and attracting private sector capital (Department of Economic Affairs 2017). These steps are critical in helping the government better manage externalization (Alford and O'Flynn 2012), might potentially enhance the effectiveness of P3 projects in terms of process considerations, and lead to cost-saving and efficiency gains. However, they are unlikely to address the programmatic goals of the government or the concerns of target populations, as these goals of effectiveness are not consciously built into current design and evaluation frameworks.

The effects of such neglect are evident from case-study evidence on current and past P3 projects. In their case-study of SWAN Municipal General Hospital – Mumbai's first BOT project for hospital care, Bisht and Virani (2016) show how P3s can yield unequal outcomes for different groups of stakeholders.[3] The project was set up when the city government was purportedly under financial strain and did not have the resources to refurbish an existing public maternity hospital that had been used for obstetric care by generations of women from the nearby slums. The government was unable to find funds for operating the upgraded facility, and handed over management of the hospital to a charitable Non-Governmental Organization (NGO) on a caretaker and no-profit-no-loss basis for 30 years in 2002.[4] The allotment of prime land without lease rent was a major attraction for the private partner, as it reduced their requirement for capital and shortened the project's gestation period. The partner also received tax benefits and subsidies from the government, and license to build additional infrastructure for new medical specialties for private clients, in return for subsidized care on select services for a defined number of poor patients at capped government prescribed rates. While service quality and the range of service offerings improved under this new arrangement due to the influx of private clients, utilization by poor patients reduced significantly as the quantum of assured services was inadequate, and because patients were unable to access unreserved services not covered by the contract without additional payment. Poor patients reported gatekeeping, malpractice, overcharging, denial of care and non-adherence to prescribed allocations. As a result, a majority of pregnant women from the neighborhood were forced to travel to seek care at another public maternity hospital, overcrowding that facility and forcing further referrals due to patient overload. The government had no supervisory oversight over day-to-day operations, and

contractual ambiguities and the insufficiency of contractual obligations of the private partner, made it difficult for the government to find a long-term resolution of patient grievances. Lack of redress mechanisms encouraged political patronage and interference. After legal challenges from the government and a notice to evict, the issue was settled out of court, albeit with a temporary fix and without substantive review of the underlying design problem.

A similar pattern of outcomes is observed in the Indraprastha Apollo Hospital project. The project is a joint venture between the Government of the National Capital Territory of Delhi (GNCTD) and the Apollo Hospital Group, for which the government provided land on a 30-year renewable lease for a token annual payment, shared initial building expenses and provided equity capital for the startup. The private partner supplied the equipment and the remaining capital, and became responsible for managing hospital operations beginning in 1994. It was entitled to generate and retain revenue, in exchange for providing contractually specified speciality services to a defined number of poor patients free of cost, on referral by the government authority. While the venture has been a commercial success, and the private partner has reaped major financial gains from the flagship project, like SWAN, it too has faced public interest litigations for breach of contract conditions, failure to provide public information, gatekeeping and overcharging patients who were otherwise eligible for free treatment (Central Information Commission 2015; High Court of Delhi 2009; Lefebvre 2010; SAMA 2012; Thomas and Krishnan 2010). The government has been either unable or unwilling to curb this behavior, due to ineffectual representation in hospital governance and a potential conflict of interest, as it has supervisory responsibilities as the public authority but also holds part equity. As a result, the hospital is a major provider of tertiary care facilities in the city for the social and political elite, but is not functionally considered part of the city's public health system.

The Rajiv Gandhi Super-Speciality Hospital (RGSH) in Raichur showcased an absolute case of design failure that produced overall poor performance, which ultimately led to its termination. The project was set up as a joint venture between the government of Karnataka and the Apollo Hospitals Enterprise Limited (AHEL), a private company that owns and operates a chain of hospitals, clinics, diagnostic centers, and pharmacies. The hospital was started by the government to provide low-cost tertiary care in rural north Karnataka with the help of external seed funding, but its management was handed over to the private company in 2001 initially for ten years, as the government was unable to operate the facility beyond a year of its establishment. All infrastructure costs were borne by the government, while the private partner provided management expertise and personnel in exchange for the right to levy charges for patients above the poverty line. The government was obligated to reimburse the private operator for services provided to patients below the poverty line, and compensate for any losses incurred in the first three years. The operator was allowed to retain 30% of the net profit from the third year, or bill the government a service charge in case no profits were realized. An end-of-term evaluation found hospital utilization to be suboptimal, which made it difficult for the hospital to sustain operations and attain self-sufficiency. Moreover, untimely disbursement of funds by the government compelled the operator to curtail service

Table 1. P3 performance on different policy outcomes.

Key performance indicators	SWAN Municipal General Hospital	Indraprastha Apollo Hospital	Rajiv Gandhi Super-Speciality Hospital
Programmatic outcomes			
Cost of procurement (govt.)	+	–	–
Returns on investment (pvt.)	+	+	–
Price for consumers	–	–	–
Efficiency	+	+	–
Service quality	+	+	–
Utilization	+	+	–
Scale of services	+	+	–
Distributional outcomes			
Equitable access	–	–	–
Equitable cost-sharing	–	–	–
Process outcomes			
Transparent procurement	–	–	+
Contract enforcement	–	–	–
Corporate accountability	+	+	+
Participatory decision-making	–	–	–
Regulatory compliance	–	–	–
Political outcomes			
Electoral accountability	–	–	+

The symbols indicate P3 performance as more (+) or less (–) effective on the different policy outcomes. The grading is subjective based on author's interpretation of outcomes from available data.

delivery for poor patients, and reallocate resources for catering to private patients. The report also took note of fraudulent behavior by the operator in the submission of insurance claims and in equipment purchases (Department of Health and Family Welfare 2011; Karpagam et al. 2013). The government decided against renewing the contract, in part influenced by a long-term effort by lobbying groups to convert the hospital into a postgraduate teaching facility.

Table 1 summarizes the analysis of policy success in the three P3 cases. Each case was assessed subjectively based on available case-study evidence, to determine whether its performance on key indices of cost, efficiency, equity and accountability across the different policy outcomes (programmatic, distributive, process and political) in the Marsh-McConnell-Newman framework was effective (+) or not (–). While in-depth evaluations of these projects are unavailable, the case studies indicate that some stakeholders benefited significantly more than others, which may have led to diverging notions of policy success based on performance on parameters that might be critical to them. The failure of their designs and the overarching policy to effectively safeguard and cater to diverse policy goals, worked against the collaborative philosophy of P3s and led to ineffectual public policy outcomes.

4. Integrating diverse perspectives in P3 design: why and how?

This paper has attempted to demonstrate how failure to specify and address the different substrates of effectiveness can render P3s ineffective. While this paper showcases select cases of hospital-based P3 projects that have had unequal outcomes, there may be other cases which have enjoyed across-the-board success. It is not the intention to suggest that the only reasons for poorly performing P3s are differences in outcome expectations and the failure of P3s to satisfy them evenly. Rather, the limited objective is to show that projects if improperly designed, tend to produce outcomes which are inherently more

favorable for some groups of stakeholders than for others. Given the complex political economy of P3s and the circuitous accountability systems they involve, the objectives of equitable access and public accountability get the most neglected, which is ironic given that user communities are the core targets of P3 policies. It is observed that the private partner is often more instrumental in determining the sustainability of P3 projects. Business viability is a key consideration, which pushes the private partner to veto any project that does not satisfy its commercial interest. As Hodge and Greve (2011) have suggested, governments are most pliable, either compelled, willing or able to justify continuing with P3s even if they are unsuited to public interest. The large number of ineffective P3s in existence is an outcome of such accommodation.

Health sector P3s in the developing world present a mixed picture on effectiveness. While P3s have been found to lower production costs for the private partner, there is little evidence about the positive effects on overall costs of health service delivery for the government (Bisht and Virani 2016; Liu, Hotchkiss, and Bose 2008; Mills 1998). Contracting-out of health services has been known to boost performance in terms of higher outputs, widen the range of services and improve the quality of healthcare provided to private patients (Bisht and Virani 2016; Liu, Hotchkiss, and Bose 2008; Lönnroth, Uplekar, and Blanc 2006). However, evidence about the equity impact of P3s, particularly in terms of access and utilization of health services is mixed. While some researchers have observed positive effects on poor communities (Jütting 1999; Patouillard et al. 2007), many have pointed to shortcomings in public accountability (Bisht and Virani 2016; SAMA 2012), explained perhaps by arguments that P3s have shifted democratic answerability to accountability for performance (Willems and Van Dooren 2011). The India cases presented in this paper reinforce these observations. Applying the Marsh-McConnell-Newman framework to analyze their effectiveness across different conceptions of P3 success, it appears that programmatic outcomes for the private sector are usually realized, but those representing public sector interests are easily neglected, especially in terms of poor distributional outcomes for indigent populations. While few studies have sought to assess their process and political outcomes, healthcare P3s in their current form enjoy limited public support and approval, which is ironic given their increasingly prevalent policy role.

How can policymakers reconcile distinct stakeholder interests via design? P3s that are better able to align key perspectives in their designs are likely to be more successful in achieving their goals. The alignment might be brought about at different stages in the policy lifecycle, and through multiple avenues and modes of governance. Partnership agreements or contracts are the main instruments through which such alignment is typically implemented and enforced (Iossa and Martimort 2009). Governance Boards provide hierarchical oversight to ensure stakeholder accountability (Lakshmy 2015). In addition, networks play an important role. The need for co-operation and collaboration applies to both design and implementation (Newman 2017). It might, for example, take the form of relational contracts that can be renegotiated from time to time to keep them mutually beneficial, in light of new information and experiential learning (Darwin, Duberley, and Johnson 2000). At the implementation level, Project Coordination Committees provide onsite monitoring, dispute resolution and correctional channels to keep interests aligned (Darwin, Duberley, and Johnson 2000). Public consultation and

feedback activities seek to elicit public involvement and participation in design and evaluation, so that P3 projects are democratically accountable and deliver public interest outcomes (Behn 1998, 2001; Watson 2003). P3 designs thus need to deploy a variety of instruments to ensure that stakeholder interests are systematically identified and continually addressed so that they are sustainable and effective. While alignment is critical, government capacity to design, implement and monitor partnerships is equally important, as P3s with sophisticated market players are susceptible to marginalization of the public-interest dimensions, in the absence of stringent government control (Alford and O'Flynn 2012; Bali and Ramesh 2019; Jütting 1999; Mills 1998; Ramesh 2008).

Given their complexity, P3s are inherently risky instruments which need to be accompanied by appropriate governance mechanisms to ensure their effectiveness. This is operationalized through both formal and informal institutions. Contracts are the formal vehicle through which project risks are allocated among stakeholders, and strategies for their management specified (Alford and O'Flynn 2012; Iossa and Martimort 2009). Yet, most contracts are inherently incomplete due to information asymmetries, and cognitive and logistic limitations (Eggleston, Posner, and Zeckhauser 2000; Hart and Moore 1988, 1999; Tirole 1999), creating avenues for risk-averse partners to engage in regulatory opportunism and moral hazard (Grossman and Hart 1986; Iossa and Martimort 2009). Task bundling arrangements (such as concession of both construction and operational control to a single private player) are other formal mechanisms through which such risk is managed (Hart 2003; Martimort and Pouyet 2008). However, purely transactional approaches have drawbacks in terms of their ability to keep stakeholder interests continually aligned. Informal mechanisms such as relational contracts and collaborative action platforms that leverage trust and cooperation among partners are indispensable for effective and long-term management of unanticipated risks and other externalities (Darwin, Duberley, and Johnson 2000). They strengthen the collaborative underpinnings of public-private hybrids and make partners sensitive to others' motivations, and more accommodative of their concerns.

Notes

1. While this assumes a linear causal relationship between policy designs and policy effects, and ignores complex interactions in policymaking, such simplification is characteristic of design studies which are essentially technocratic (Peters 2018a). There has been recent recognition that technically-oriented designs are prone to normative biases (Kuehnhanss 2019), and that design thinking can be adapted to address political problems in social policy, albeit requiring a different set of critical capacities (Bali and Ramesh 2019; Chindarkar, Howlett, and Ramesh 2017).
2. The policy is oriented towards hard infrastructure projects where the rationale for P3s is easier to justify, objectives are well-defined and assessments more straightforward, as against soft service projects where the goals are nebulous and their linkage with stated deliverables is unclear. For example, the draft policy suggests an annuity-based BOT model for social sector P3s as economic returns are less assured, but is silent on how economic evaluations are to be conducted or how value for money (VfM) is to be ascertained, given the special nature of healthcare and its welfare characteristics, and the technically unreliable and suspect nature of VfM assessments (Hodge and Greve 2010).
3. The hospital's identity and that of other parties in the contract was masked in the original study to preserve anonymity. The same is maintained.

4. The hospital was given to the private partner on rent-free lease on the principle that profits generated from private operations would be used to cross-subsidize care and provide affordable treatment to the indigent.

Disclosure statement

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ORCID

Altaf Virani http://orcid.org/0000-0001-8377-1641

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